STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155368	A. BUILDING _____ B. WING _____	C 05/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TODD-DICKEY NURSING AND REHABILITATION	**712 W 2ND ST LEAVENWORTH, IN 47137**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00199557 and IN00199810. Complaint IN00199557 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00199810 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: May 12 and 13, 2016 Facility number: 000490 Provider number: 155368 AIM number: 100291320 Census bed type: SNF/NF: 41 Total: 41 Census payor type: Medicare: 4 Medicaid: 27 Other: 10 Total: 41 Sample: 6 Todd-Dickey Nursing and Rehabilitation was found to be in compliance with 42 CFR 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigations of Complaints IN00199557 and IN00199810. Quality Review Completed by 34233 on May 17, 2016 `	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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